HEALTH REPORT

Student's Name _____

myCayuga ID Number _____

Please read, respond, and return this Health Report to:

Health Office
Cayuga Community College
197 Franklin Street
Auburn, NY 13021

New York State Public Health Law 2167 requires colleges to distribute information about meningococcal disease and vaccinations to ALL students taking 6 credit hours or more (on campus). A signed reply is then required from the student. This report includes the reply section for your signature.

New York State Public Health Law 2165 requires proof of immunity to measles, mumps and rubella. This law is mandatory for ALL college students born in 1957 or later and registered for six (6) credit hours or more (on campus).

Students who will work in the campus **Preschool Center** as part of their curriculum must have a physician complete Part V—Preschool Center Students Only section of this report.

Nursing and Occupational Therapy Assistant Students are required to have an annual physical examination (use last page of this report) and must complete Part IV—Nursing and Occupational Therapy Assistant Students Only section in this report.

Members of College **athletic teams** are also required to have an annual physical examination (use last page of this report).

Information recorded on this form is confidential and will not be shared outside of this institution without your consent.

Cayuga Community College

197 Franklin Street • Auburn NY 13021

Social Security # _____ Date of Birth_____

Name_____
Last First Middle

Home Address _____
Number and Street

_____
City State Zip

Phone (with area code) ( ) _____

Address while attending Cayuga (if same as above, write "SAME"): _____

Address at school _____

Phone (with area code) ( ) _____

Person to notify in case of emergency _____

Phone (with area code) ( ) _____

HEALTH HISTORY

Place an "X" in the appropriate box(es):

❒ Anemia	❒ Depression	❒ Headaches (recurrent)	❒ Scarlet Fever
❒ Arthritis	❒ Diarrhea (recurrent)	❒ Heart Problem/Murmur	❒ Sinusitis
❒ Asthma	❒ Diabetes	❒ Hepatitis	❒ Sore Throat (frequent)
❒ Back Problems	❒ Digestive Problems	❒ Jaundice	❒ Tuberculosis
❒ Blood Disorder	❒ Dizziness/Fainting	❒ Joint Disease/Injury	❒ Ulcerative Colitis
❒ Chicken Pox	❒ Ear Trouble	❒ Kidney Disease	❒ OTHER (specify):
❒ Colds (frequent)	❒ Eye Trouble	❒ Pneumonia	_____
❒ Convulsion/Seizure	❒ Hay Fever	❒ Rheumatic Fever	_____

* *Disclosure of personal information is voluntary and does not affect your acceptance at Cayuga*

Please list any allergies to food, drugs, etc. _____

Do you take any medications regularly? ❒ Yes ❒ No If "Yes," please list drug(s) and dosage(s)_____

_____

Please list any serious injuries, illness, fractures, dislocations or surgeries: _____

Do you have any disability or impairment of which we should be aware? _____

Are you currently receiving treatment at a clinic or by a physician (other than regular check-ups)? ❒ Yes ❒ No

If "Yes," please explain: _____

IMMUNIZATION RECORD

Part I: REQUIRED A or B by NYS PHL 2165

A. **M.M.R.** (Measles, Mumps, Rubella) 2 doses required. Date of MMR #1 _____ Date of MMR #2 _____

OR

B. **Measles** (Rubeola) 2 dates of measles immunization. Both doses must be given after 1967.

First Date _____ Second Date _____

OR Date of Measles Titer_____ Results ❒ Positive ❒ Negative

Mumps Date of at least one mumps immunization. First Date _____ Second Date _____

OR Date of Mumps Titer _____ Results ❒ Positive ❒ Negative

Rubella (German Measles) Date of at least one rubella immunization. First Date _____ Second Date _____

OR Date of Rubella Titer _____ Results ❒ Positive ❒ Negative

Part II: REQUIRED A or B by NYS PHL 2167

Meningococcal Meningitis vaccine (check one box only)

A. ❒ Had meningococcal meningitis vaccine within past 5 years (Menomune™ Menactra™, Menveo™) Date _____ Attach Record

B. ❒ I have read, or have had explained to me, the information regarding meningoccocal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease at this time.

I understand that I may choose to seek vaccination in the future.

Signature of Student (Parent/Guardian for student under age 18) _____ Date _____

Part III: RECOMMENDED VACCINES AND TESTING

Tetanus (TD) Booster Date _____ (within 10 years)

Tuberculin Skin Test (PPD) Test Date _____Results ❒ Positive ❒ Negative

Hepatitis B Vaccine: Date #1 _____ Date #2 _____ Date #3 _____

Part IV: NURSING AND OTA STUDENTS ONLY

1. **REQUIRED MMR** (Measles, Mumps, Rubella)

Date of MMR #1 _____ Date of MMR #2 _____

OR

Date of MEASLES TITER _____ Results _____

Date of MUMPS TITER _____ Results _____

Date of RUBELLA TITER _____ Results _____

2. **REQUIRED TB Tuberculin Skin Test (PPD)** (yearly) Date of PPD _____ Results _____

If Positive PPD, date of Chest X-ray _____ Results _____

3. **REQUIRED Tetanus (TD)** within 10 years

Date of TD _____ **OR** Date of TDAP _____

4. **REQUIRED Chicken Pox/Varicella**

Date of CP Disease _____ **OR** Date of Antibody Titer _____ Results _____

OR Date of CP Vaccine #1_____ #2_____

5. **RECOMMENDED Hepatitis B Vaccination Series** Date of Hep B #1 _____ Date of Hep B #2 _____ Date of Hep B #3_____

OR Date of Antibody Titer_____ Results _____ **OR** Declination of Hepatitis Vaccination _____

Signature Date

Part V: PRESCHOOL CENTER STUDENTS ONLY

1. Is this person free of communicable diseases? ❒ Yes ❒ No
2. Is this person physically fit to take part in this program? ❒ Yes ❒ No
3. Tuberculin skin test (PPD) Date_____ Results_____

_____ _____

Signature of Physician/NP/PA **Date**

PHYSICAL EVALUATION (To be completed by the Physician/NP/PA)

Name: _____

Sex: ❒ Male ❒ Female Height _____ Weight _____

Blood Pressure: Sitting _____ Standing _____

Uncorrected Vision: Rt. 20/___ Left 20/___ Corrected Vision: Rt. 20/___ Left 20___/

Are there any irregularities of the following systems?

	Yes	No
Head	❒	❒
Neck	❒	❒
Eyes	❒	❒
Ears	❒	❒
Nose	❒	❒
Throat and Teeth	❒	❒
Heart	❒	❒
Lungs	❒	❒
Breasts	❒	❒
Abdomen	❒	❒
Genito-Urinary	❒	❒
Extremities	❒	❒
Skin	❒	❒
Skeletal	❒	❒

Use this area to describe fully any positive findings and clarify recommendations:

Recommendations for physical activity (physical education, nursing clinicals, intercollegiate sports):

❒ **Unlimited** ❒ **Limited** If "Limited," please explain: _____

_____

_____

Signature of Physician/NP/PA _____ **Date** _____

Address _____

Phone ( ) _____

Please return this form to:

College Health Service Office
Cayuga Community College
197 Franklin Street
Auburn, NY 13021-3099